State of California Department of Consumer Affairs

Speech-Language Pathology and Audiology Board
2005 Evergreen Street, Suite 2100, Sacramento, CA 95815
Telephone: (916) 263-2666 / Fax: (916) 263-2668
www.slpab.ca.gov

TERMINATION OF SUPERVISION
FOR SPEECH-LANGUAGE PATHOLOGY ASSISTANT

Division 13.4 of Title 16, California Code of Regulations Section 1399.170.18 requires that at the time of termination of supervision, the supervisor shall submit this original signed form within fourteen days of the termination of supervision.

_____ Speech-Language Pathology Assistant's Name	_____ SPA Number
_____ Supervisor's Name	_____ License or SSN Number

I, _____ certify that I supervised _____, in performing the duties and functions of a speech-language pathology assistant in accordance with Section 1399.170.15 of the California Code of Regulations from _____ to _____.

I declare under penalty of perjury under the laws of the State of California that I have read and understand the foregoing and the information submitted on this form is true and correct.

_____ _____ _____
Printed Name of Qualified Supervisor | Signature of Qualified Supervisor | Date

_____
Mailing Address: No. & Street | City | State | Zip Code

(_____)_____
Qualified Supervisor's Daytime Telephone Number

The **original** of this form must be mailed to:

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Sacramento, CA 95815